

Children's Waiver
Environmental/Vehicle Modification and Assistive/Adaptive Technology
PRE-PROJECT EVALUATION PAYMENT REQUEST FORM

Recipient Name: _____ **Medicaid CIN:** _____

Project Type: (Check One) Assistive/Adaptive Technology Environmental Modification
 Vehicle Modification

Describe the proposed project/request:

Evaluator Information

Evaluator Business Name: _____

Evaluator Contact Name: _____

Evaluator Phone: _____ Email: _____

Signature of Evaluator: _____ Date: _____

Evaluation Information

Type of Evaluation: _____

Pre-Project Evaluation Cost: \$ _____

Date of Pre-Project Evaluation: _____

Address of Pre-Project Evaluation: _____

Evaluation Acknowledgement and Approval

Name of HHCM/CYES: _____ CMA: _____

Signature of HHCM/C-YES: _____ Date: _____

By checking this box, the LDSS confirms approval of this evaluation

LDSS Representative Name: _____ County: _____

Signature of LDSS Representative: _____ Date: _____

SUBMISSION – Submit this form along with the pre-project evaluation and/or associated invoice(s) via secure email to EModVModAT@health.ny.gov. For FAQs and guidance, visit [here](#):